90-440

No. 90-___

In The

Supreme Court of the United States

October Term, 1990

JERRY B. LUNN (Deceased) and KAREN L. LUNN,
Petitioner,

v.

TIME INSURANCE COMPANY,
Respondent.

On Petition For Certiorari To The Supreme Court Of New Mexico

PETITION FOR CERTIORARI

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QUESTIONS PRESENTED FOR REVIEW

1. Whether the court below erred in holding that all of the claims of Petitioner, both extracontractual and contractual, were preempted by the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. Sec. 1001, *et seq.*, when Petitioner and JERRY LUNN were independent contractors, hired upon a temporary basis, and were not "participants" under the ERISA employee welfare benefit plan ("plan")?

(a) In light of the uniform law of the circuits in cases such as *Darden v. Nationwide Mut. Ins. Co.*, 796 F.2d 701 (4th Cir. 1986), *Jackson v. Sears, Roebuck & Co.*, 648 F.2d 255 (5th Cir. 1881) and *Giadono v. Jones*, 867 F.2d 409 (7th Cir. 1989) holding that in order for litigants to have a remedy under ERISA they must be an employee participant or beneficiary under an ERISA plan, did the court below err in holding that Petitioner and JERRY LUNN, non-participants of the plan, had a remedy under ERISA?

(b) Did the court below err in holding that Petitioner and JERRY LUNN, independent contractors hired on a temporary basis, were non-participants under the plan?

(c) Did the court below err in holding that they were not clear if Petitioner and JERRY LUNN were not participants under the plan?

QUESTIONS PRESENTED FOR REVIEW – Continued

(d) Was the court below correct in stating that it was irrelevant if Petitioner and JERRY LUNN were participants under ERISA when the court held that all of Petitioner's claims were preempted under ERISA and that Petitioner's only remedy was under ERISA?

(e) Did the court below properly understand and apply the decision in *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987) in preempting and dismissing all of Petitioner's claims, when the United States Supreme Court in the *Pilot Life* case held that the purpose of ERISA was to protect participants and beneficiaries in employee benefit plans, and the Petitioner and JERRY LUNN were not participants or beneficiaries of the plan?

2. Should the Supreme Court exercise its judicial discretion to grant certiorari in this case where the right of Petitioner to recover damages is forfeited and preempted by a state court applying federal law as in *Kolovrat v. Oregon*, 366 U.S. 187 (1961)?

LIST OF PARTIES

All the parties are listed in the caption of this case.

TABLE OF CONTENTS

TABLE OF CONTENTS – Continued

TABLE OF AUTHORITIES

Page

CASES

STATUTES

TABLE OF AUTHORITIES – Continued

OPINIONS BELOW -

The opinion of the Supreme Court of New Mexico, filed May 15, 1990, is reported at 792 P.2d 405 (1990) and reprinted in the Appendix at pages App. 9 through App. 16. The trial court's Summary Judgment, of September 7, 1990 holding that Petitioners' claims were preempted by ERISA is unreported. It is reproduced here in the Appendix at pages App. 1 through App. 8.

JURISDICTION

The original decision and opinion of the state appellate court were entered on May 15, 1990. A timely Petition for Rehearing was filed on May 30, 1990. On June 14, 1990, the Petition for Rehearing was denied. This petition for writ of certiorari is filed on September 12, 1990, within ninety (90) days of June 14, 1990.

This Court has jurisdiction to review the judgment and opinion of the New Mexico Supreme Court under 28 U.S.C. Sec. 1257(a) and Supreme Court Rule 10.1(b) and (c).

CONSTITUTIONAL PROVISIONS, STATUTES AND REGULATIONS INVOLVED

There are no constitutional provisions involved, except for the Supremacy Clause of the United States Constitution. The provisions of the federal statutes involved, the Employment Retirement and Security Act of 1974, 29 U.S.C. 1001, et seq. are lengthy. The pertinent text of Secs. 1001, 1001a, 1001b, 1002, 1132 and 1144 of the Act are set forth at page App. 32 through App. 47 of the Appendix.

STATEMENT OF THE CASE

A. Facts and proceedings leading to the trial court action.

The Petitioner and JERRY LUNN were hired by Trans-American Communications, Inc. (Employer), in El Paso, Texas for temporary jobs as cable splicers. The Respondent and both courts below concede that Petitioner and JERRY LUNN were independent contractors. Employer entered into a contract of insurance with Respondent to provide major medical insurance for its employees. Employer paid one-half of the premiums to Respondent and the employees paid one-half of the premiums.

The Petitioner KAREN LUNN made inquiry of Employer if she could apply for insurance coverage with Respondent with her husband, JERRY LUNN to be covered as her dependent. The Employer stated that it was okay with him as long as Employer paid no portion of the LUNNS' premiums and stated that so long as they had no expectations from Employer concerning insurance benefits, that it was solely between the LUNNS and Respondent. The LUNNS paid all of their premiums.

The Respondent accepted the Petitioner's application, which was approved by Respondent's underwriter on March 31, 1986.

Coverage for the LUNNS was made effective, retroactively to March 1, 1986. Petitioner KAREN LUNN was issued an insurance identification card.

In June of 1986, JERRY LUNN developed colon cancer. He began treatment for this condition on June 3, 1986.

Claims forms were filed with Respondent by Petitioner KAREN LUNN, beginning in June of 1986. The medical, hospital and surgical bills incurred by JERRY LUNN were extensive. On November 26, 1986, Petitioner was notified by Respondent that her claim was denied on the ground that they were independent contractors and, therefore, were not covered under the insurance policy in question. Petitioner's attorney requested Respondent to point out the clause in the plan excluding independent contractors from coverage. Although Respondent refused to point out any such clause, it replied through its corporate counsel that independent contractors were not covered under this policy. Subsequent to the denial of Petitioner's claims on the basis that independent contractors were not covered under the plan, Respondent alleged that Petitioner had misrepresented JERRY LUNN'S previous medical condition. (App. 27-29). The plan covered a preexisting condition if "medical care, treatment, medicine or advice" was not received for an illness or injury during the six-month period immediately prior to the effective date of the coverage. Carl Kelley, Jr., an officer of the corporation testified that JERRY LUNN told him about a previous medical problem he had in the context of the preexisting condition clause and that Mr. LUNN asked Mr. Kelley if this information should be put down prior to the application being signed. At the time of this conversation the insurance clerk, Pam Harder, was present.

B. Proceedings in the Trial Court.

On August 10, 1987 the LUNNS filed suit in state court in Santa Fe County, New Mexico, alleging the

failure of Respondent to pay medical and hospital expenses under the policy, for damages in excess of $60,000, statutory penalties and attorneys fees, for bad faith refusal to pay a just claim and for punitive damages. The Petitioner's Complaint is set out verbatim at pages App. 20 through 24 in the Appendix. On August 17, 1987, JERRY LUNN died of colon cancer. Petitioner has maintained the litigation on behalf of herself, individually, and as representative of JERRY LUNN'S estate.

The ERISA defense was raised by Respondent on or about September 25, 1987, when it filed its answer in the trial court in which it alleged as its Eighth Affirmative Defense, generally, that Petitioner's claims were "preempted by federal law" that such claims "are barred under the Constitution of the United States by reason of the Supremacy Clause". The Respondent's Answer filed in the trial court is set forth verbatim at pages App. 25 of the Appendix through App. 30.

Subsequent to the Respondent's Answer being filed, the parties conducted extensive discovery, including six depositions. On May 16, 1987, almost two years after suit was filed, and after considerable litigation expense, Respondent filed its Motion for Summary Judgment based upon ERISA preemption wherein it was alleged, in part, that the Respondent expected that the trial court may allow the Petitioner to amend under ERISA.

Petitioner filed a Response to the Respondent's Motion for Summary Judgment wherein it was alleged that Petitioner was an independent contractor and not a

participant under the plan, that Petitioner had no remedy under ERISA and therefore, her claims were not preempted thereby. In addition, Petitioner presented various matters by way of summary judgment proof, including the proffer of proof by an insurance expert retained by Petitioner to demonstrate that any judgment for money damages would not adversely effect the plan due to the industry custom of establishing reserves for claims. The trial court, in the hearing of September 7, 1990, agreed that the facts were not disputed.

On August 8, 1989, the Court ruled that Summary Judgment would be decided in favor of Respondent. On September 7, 1989, the trial court overruled Petitioner's Motion to Reconsider Summary Judgment and entered Summary Judgment for the Respondent. The Summary Judgment is set forth verbatim at App. 1 though App. 8. The trial court held that if ERISA preempts state law claims of employees in a plan, it also preempts the same state law claims for an independent contractor if the independent contractor is seeking the same benefits under the plan. (App. 7). The trial court also ruled that Petitioner's exclusive remedy was through ERISA (App. 7). However, as stated above, Petitioner was seeking more than benefits under the plan in her complaint. (App. 20 though App. 24). Petitioner filed a Motion for New Trial, but the trial court refused to act upon it, and same was overruled by operation of law. Throughout all of the proceedings in the trial court, in her Response to Motion for Summary Judgment, Motion for Court to Reconsider Order Granting Summary Judgment, Reply to Respondent's Opposition to Motion to Reconsider and Motion for New Trial, Petitioner continued to assert that her

claims were not preempted by ERISA because she and JERRY LUNN were independent contractors, not employees and thus not participants in the plan and that ERISA preemption only applies to plan participants.

C. Proceedings in the New Mexico Supreme Court.

In accordance with New Mexico appellate procedure, the Petitioner appealed her case directly from the trial court to the New Mexico Supreme Court.

Oral argument was held before the state appellate court on April 10, 1990. On May 15, 1990, the court filed its opinion. The opinion is reported at 792 P.2d 405 (1990) and is reprinted in the Appendix at pages App. 9 through App. 16.

The opinion concedes that Petitioner and JERRY LUNN were cable splicers, retained by the Employer as independent contractors. The court states that Mrs. LUNN did not indicate on the form that she was an "independent contractor". Mrs. LUNN wrote in on the insurance application form that she was a cable splicer under the line requesting information under "job duties". A copy of the Time Insurance Company form in question is found at page App. 31 in the Appendix.

Throughout Petitioner's Brief and Reply Brief in the lower court, it was continually asserted that Petitioner and JERRY LUNN were not participants in the plan, therefore they had no remedy under ERISA and their claims should not be preempted.

The state appellate court relied upon *Darden v. Nationwide Mut. Ins. Co.*, 796 F.2d 701 (4th Cir. 1986) and

Jackson v. Sears, Roebuck & Co., 648 F.2d 225 (5th Cir. 1986) and agreed with Petitioner that it is plausible that they were not participants under the plan. The Court recognizes that if a litigant is not a participant in an ERISA plan, then such person has no claim under ERISA, and such ERISA claim is properly dismissed. (App. 13)

On oral argument, on April 10, 1990, it was pointed out to the lower court by Respondent that if the *Darden* case and *Waxman v. Hardaway Const. Co., Inc.*, 693 F. Supp 587 (M.D.Tenn. 1988) were the law, then Petitioner would have no remedy, or "no way out". This admission was elicited by Justice Montgomery of the lower court at the beginning of Respondent's argument. The relevant portion of the *Waxman* decision is as follows:

> " . . . Thus, plaintiff's right to pursue an ERISA claim against defendants, *and this Court's jurisdiction*, depend upon whether Stanley Waxman was an "employee" for the purposes of ERISA, or whether he was an independent contractor. . . . " 693 F. Supp 587, 591 [emphasis that of the undersigned]

Citing *Pilot Life*, 481 U.S. 41 (1987) and *Straub v. Western Union Tel. Co.*, 851 F.2d 1262 (10th Cir. 1988), the court held that it was irrelevant that Petitioner and JERRY LUNN were not participants in the plan and thus, their claims were preempted under ERISA. (App. 14). The *Straub* case pertained to claims made by an employee.

Although the appellate court states at first that the Petitioner and JERRY LUNN were participants it then states it is not sure if they were participants or not. (App. 13) The appellate court acknowledges that the Petitioner has no remedy but asserts that her lack of remedy is

brought on by her asserting contractual damages and bad faith damages against Respondent.

An additional admission was elicited from Respondent by Justice Baca of the lower court on oral argument. Justice Baca asked Respondent what Mrs. LUNN'S remedy would be under ERISA. Respondent replied that her remedy would be a civil action under Sec. 29 U.S.C. 1132(a)(1)(b). Then Respondent, upon further questioning by Justice Baca, stated that a defense to such a suit would be that Mrs. LUNN was not a participant or beneficiary.

Petitioner filed a timely Motion for Rehearing with the court on May 30, 1990, pointing out to the court that this was the only known case in the entire jurisprudence of the United States where an independent contractor's claims were preempted by ERISA. The court denied Petitioner's Motion for Rehearing on June 14, 1990. (App. 17, 18).

REASONS FOR ALLOWANCE OF THE WRIT

I. THE LOWER COURT'S OPINION ERRONEOUSLY RELIES UPON THE DEFINITION OF "PARTICIPANT" IN AN ERISA EMPLOYEE WELFARE BENEFIT PLAN ISSUED BY THE FOURTH CIRCUIT COURT OF APPEALS IN *DARDEN V. NATIONWIDE MUT. INS.* EVEN THOUGH PETITIONER AND JERRY LUNN WERE INDEPENDENT CONTRACTORS AND NON-PARTICIPANTS IN AN ERISA PLAN, THE LOWER COURT NEVERTHELESS HOLDS THAT THE ONLY REMEDY THE PETITIONER HAS IS UNDER ERISA. THIS STATE COURT HOLDING IS DIRECTLY IN CONFLICT WITH THE HOLDING IN *DARDEN* AND HOLDINGS IN THE FIFTH AND SEVENTH CIRCUITS THAT NON-PARTICIPANTS HAVE NO REMEDY UNDER ERISA.

A. The state appellate court decision cannot be reconciled with *Darden v. Nationwide Mut. Ins.*, 796 F.2d 701 (4th Cir. 1986)

In *Darden*, an insurance agent was appealing from the decision of the District Court granting the Insurance Company a summary judgment on the agent's claims for retirement benefits on the basis of ERISA. Although the Fourth Circuit sent the case back to the trial court for a further determination as to whether or not the agent was an employee or an independent contractor, the Court also stated the following on the precise issue before this Court:

> " . . . To maintain an action based on Sec. 502(a) of ERISA, 29 U.S.C. Sec. 1132(a), Darden must qualify as a "participant" in an employee benefit plan. The Act defines a "participant" as "any employer or former employee of an employer . . . who is or may become eligible to receive a benefit of any type from an employee benefit

> plan which covers employees of such employer . . . 29 U.S.C. Sec. 1002(7). Thus, Darden's right to pursue an ERISA-based claim against Nationwide depends upon whether he may properly be treated as an "employee" for the purposes of ERISA, or whether he falls into the independent contractor category . . . " 796 F.2d 701, 704

The state appellate court, in equivocating on the participant issue, has not been successful in avoiding the issue. Petitioner and JERRY LUNN were, as the lower courts stated, independent contractors. This Court will surely agree that Petitioner and JERRY LUNN were non-participants in the plan.

This state appellate decision is in direct conflict with the Fourth Circuit in the *Darden* case. The *Darden* case holds that one must be a participant in an ERISA plan to sue under ERISA. The state appellate court says that even if Petitioner is a non-participant, it is irrelevant. This clearly demonstrates a misinterpretation of federal law which should be clarified by this Court. On this basis alone, the writ of certiorari should be granted and the New Mexico Supreme Court decision summarily reversed.

B. The state appellate decision is also in conflict with the uniform laws of other circuits.

Not only is the lower court opinion in conflict with the *Darden* case, but it is also in conflict with the law of at least two other circuits which have addressed the issue related to this issue of whether non-employee, non-participants are preempted by and subject to ERISA. Thus, in

Jackson v. Sears, Roebuck & Co., 648 F. 2d 255 (5th Cir. 1981), the court found that a sales representative was not a "participant" within the statutory definition of ERISA. The Fifth Circuit Court of Appeals affirmed the District Court's dismissal of the ERISA claim stating:

> " . . . Under the Act, only a "participant" or a "beneficiary" or a "fiduciary" of an employee benefit plan may bring a private civil action. 29 U.S.C. Sec. 1132. The term "participant" is defined in 29 U.S.C. Sec 1002(7) as follows:
>
> > . . . . [A]ny employee or former employee of an employer,. . . . who is or may become eligible to receive a benefit of any type from any employee benefit plan which covers employees of such employer . . . " 648 F. 2d 225, 227

In *Giardono v. Jones*, 867 F.2d 409 (7th Cir. 1989) the Court of Appeals held that the District Court does not have subject matter jurisdiction under ERISA unless the suit is brought by the Secretary of Labor, or by a participant, beneficiary or fiduciary, that is, those litigants enumerated by ERISA. In *Giardono* a non-participant employer filed a cross-action under ERISA alleging breach of fiduciary duty. The Court held it was without subject matter jurisdiction to entertain the ERISA counterclaim.

What has occurred in the courts below is that Petitioner went to state court armed with overwhelming authority that there was no jurisdiction in the courts as to her case under ERISA. Nevertheless, the state court, by incorrectly applying Federal law, throws her out of court by saying the claims should have been filed under ERISA. Petitioner has no remedy against Respondent unless this Court grants certiorari.

II. THE LOWER COURT DID NOT PROPERLY APPLY THE DECISION IN *PILOT LIFE INS. CO. V. DEDEAUX*, 481 U.S. 41 (1987) TO THIS CASE IN THAT THE LOWER COURT PREEMPTED AND DISMISSED ALL OF PETITIONER'S CLAIMS BASED UPON *PILOT LIFE* WHEN THE UNITED STATES SUPREME COURT HELD IN *PILOT LIFE* THAT THE PURPOSE OF ERISA WAS TO PROTECT PARTICIPANTS AND BENEFICIARIES IN EMPLOYEE WELFARE BENEFIT PLANS, AND THE PETITIONER AND JERRY LUNN WERE NOT PARTICIPANTS OR BENEFICIARIES OF THE PLAN.

The state appellate court, in discussing the intention of Congress in enacting ERISA states the following:

> " . . . Congress intended that the preemption clause should be interpreted broadly in light of the comprehensive nature of ERISA. *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 44 (1987) . . . " App. 11

However, in its discussion of *Pilot Life*, the state court neglected to state what the United States Supreme Court stated was the purpose of Congress in enacting ERISA. Thus, Justice O'Connor described Congress' intent as follows:

> " . . . In ERISA, Congress set out to "protect . . . participants in employee benefit plans and their beneficiaries, by requiring the disclosure and reporting to participants and beneficiaries of financial and other information with respect thereto, by establishing standards of conduct, responsibility, and obligation for fiduciaries of employee benefit plans, and by providing for appropriate remedies, sanctions, and ready access to the Federal courts." Sec 2, as set forth

> in 29 USC Sec 1001(b) [29 USCS Sec 1001(b)] . . . " 95 L Ed 2d 39, 39

The above language was stated in the context of a claim by an employee, or participant of a plan in *Pilot Life*. Dedeaux was an employee and one-half of his insurance premiums were paid by the employer. Petitioner and JERRY LUNN were non-participant independent contractors who paid all of their premiums. Dedeaux has a remedy under ERISA. Petitioner has no remedy under ERISA. If the preemption of Petitioner's claims is allowed to stand, then Petitioner has no remedy against Respondent. That would be a serious injustice.

Further, this Court in *Pilot Life* states that the civil enforcement scheme set forth in 28 U.S.C. 1132(a) is one of the essential tools for accomplishing the stated purpose of ERISA, quoting in a footnote this enforcement section. 95 L Ed 2d 39, 51 Of course, this provision enumerates only four classes of individuals who are entitled to sue under ERISA, (1) participants, (2) beneficiaries, (3) fiduciaries, and (4) the Secretary of Labor. It has been held that this section is a matter of subject matter jurisdiction. *Giarodono v. Jones*, supra.

Courts have acknowledged the difficulties in applying ERISA preemption to employee-participants' common law claims. Thus, in *Amos v. Blue Cross-Blue Shield of Alabama*, 868 F.2d 430 (11th Cir. 1989) the Eleventh Circuit Court of Appeals, after reluctantly holding that some employees' common law claims were preempted under ERISA, concluded as follows:

> " . . . We acknowledge that by eliminating the possibility that insurance companies may be liable for punitive or extra-contractual damages,

> the courts are removing an historical disincentive to insurance company misbehavior. Consequently, our decision may produce unintended results. However, any change in the law's course will have to be charted by the Congress or the Supreme Court . . . "868 F.2d 430, 433

In the *Amos* case, the claimants still had a remedy, albeit limited, under the ERISA civil enforcement provisions. If the lower court decision stands, Petitioner has no remedy against Respondent. Petitioner trusts that she will be granted a remedy by the Court granting this writ of certiorari.

CONCLUSION

This case presents an important matter of federal statutory law which needs to be reviewed by this Court. This is the first case in the United States where an independent contractor, because of an ERISA preemption, has no remedy. Petitioner would urge that the policy considerations set forth by Congress in 29 U.S.C. Secs. 1001, 1001a and 1001b do not encompass the result reached by the lower court in this case. Affording Mrs. LUNN a remedy in this case would not impair the Congressional policy, namely to protect "participants" and "beneficiaries". To allow the lower court decision to stand would serve no purpose except to fulfill the prophecy of the Eleventh Circuit Court of Appeals in *Amos*, supra, and remove some more of the "historical disincentive to insurance company misbehavior". The lower court opinion is squarely in conflict with decisions in the Fourth, Fifth and Seventh Circuits, any of which, had Mrs. LUNN

been before them, would have afforded her a remedy against Respondent.

Petitioner respectfully prays for the grant of this writ of certiorari. At issue here is a most important question of federal jurisprudence and statutory construction. If the lower court decision stands, the result is that a state court's erroneous interpretation of a federal statute preempts Petitioner's claims, denying her a remedy against Respondent, as Respondent denied JERRY LUNN major medical coverage during his last months of life, while dying of colon cancer. This is a fundamental damage suit for an alleged grevious wrong. This is a suit against Respondent, not against the plan. JERRY LUNN has already suffered all that is possible. The lower court has never explained how he could enforce any benefits under the plan. Preemption does not apply.

The state court decision, if allowed to remain, will also have a disastrous effect on other independent contractors, who may be in the same position as Petitioner. Insurers do not normally refuse premiums. However, the New Mexico Supreme Court has granted any insurer ample authority to deny any claim presented by any independent contractor so long as an ERISA plan is involved. Congress did not intend this result. Surely this Court will allow the Petitioner a way out of the seemingly remediless quagmire woven around her claims by the misinterpretation and plain disregard of a federal statute.

Respectfully submitted,

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FIRST JUDICIAL DISTRICT COURT
COUNTY OF SANTA FE
STATE OF NEW MEXICO
No. SF 87-1640(C)

(ENDORSED SEP 07 1989)

JERRY B. LUNN, and wife,
KAREN D. LUNN,

Plaintiffs,

v.

TIME INSURANCE COMPANY,

Defendants.

SUMMARY JUDGMENT

THIS MATTER coming on for consideration upon Defendant Time Insurance Company's ("Time") Motion for Summary Judgment and the Court having considered the memoranda filed, the exhibits thereto, the cases and slip opinions cited by counsel and the entire file in this matter, the Court concludes that the motion is well taken, and that the same should be granted. The following shall constitute the Court's Findings of Fact and Conclusions of law:

The following facts are undisputed by the parties:

1. Plaintiff, Karen L. Lunn, on behalf of herself and her deceased husband, Jerry B. Lunn, has sued Defendant Time alleging an improper denial of a claim for medical benefits under an employees' group health insurance policy ("the Time MET Plan") purchased by Trans-American Communications, Inc. ("Trans-American") from Time. Count I of the Complaint alleges that time breached the

group insurance contract by failing to pay claims for medical treatments for Mr. Lunn. Count II alleges that Time acted in bad faith in denying the Plaintiff's claims under the employee group policy in question.

2. Trans-American arranged for and maintained the Time MET Plan in order to provide medical and death benefits for its employees.

3. Trans-American's employee, Pam Harder, who was responsible for obtaining insurance coverage for Trans-American's employees, testified that the Time MET Plan "is a benefit, or at least the premiums paid for that is a benefit that Trans-American Communications gives to its employees."

4. Plaintiff, Karen Lunn was not an employee of Trans-American; at the time she applied for coverage under the Time MET Plan maintained by Trans-American, she and her husband had been hired, on a temporary basis, as independent contractors, to splice cables for Trans-American.

5. When Trans-American's president applied for the Time MET Plan he signed an agreement stating, in relevant part,

> The Employer understands that only full-time employees and their dependents are eligible for coverage. It is agreed that the employer will pay at least the required premium for the employees.

6. In order to fund the Time MET Plan, Trans-American deducted one-half of the costs of insurance coverage from each individual employee's salary, contributed the remaining half of the cost, and then remitted the full cost

of insurance to Time. In the case of the Lunns, however, because of their status as independent contractors, Trans-American deducted the full cost of their coverage under the Time MET Plan from checks paid to the Lunns and made no contribution itself toward the cost of the Lunn's coverage.

7. When Mrs. Lunn applied for coverage under Trans-American's employee group health plan, she signed a form stating in relevant part:

> I hereby authorize my employer to deduct from my earnings the proper deductions, if any, as contributions towards the cost of this insurance. I am employed by the employer listed and regularly work at least thirty hours per week. I request insurance coverage under the group policy(ies) issued by Time Insurance.

8. When Time learned that Karen Lunn was not an employee of Trans-American, it rescinded Mrs. Lunn's coverage, tendered to her the premiums she had paid, and informed her that neither she nor Mr. Lunn qualified for benefits under that plan.

ANALYSIS

Based on the foregoing undisputed facts Time argues that the Time MET Plan offered by Trans-American to its employees through the purchase of insurance from Time Insurance Company is an "employee welfare benefit plan" as defined and governed by the Federal Employment Retirement Income Security Act of 1974 (ERISA) 29 U.S.C. § 1001 et seq. Further, Time argues, ERISA preempts all state law claims "relating to" an employee

welfare benefit plan. Because Mrs. Lunn is seeking benefits she claims are due to her under Trans-American's employee welfare benefit plan, her claims "relate to" that plan. Thus, if she has any right to sue Time, that right must be found in ERISA itself. Having failed to properly allege a cause of action under ERISA, Summary Judgment should be entered against the Plaintiff.

In response to the Motion for Summary Judgment, Mrs. Lunn argues first that the Time MET Plan is not an "employee welfare benefit plan" subject to ERISA. Second, she argues that even if the plan is subject to ERISA, her state law claims are not preempted. Third, she argues that she cannot be subject to ERISA because she was an independent contractor, not an "employee" of Trans-American.

Based upon the plan language of ERISA itself, and numerous decisions which hold squarely that insurance policies maintained by employers like Trans-American for their employees, the Court concludes that by purchasing a comprehensive group health plan for its employees "providing for its participants or their beneficiaries . . . medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability [or] death" (29 U.S.C. § 1002), Trans-American established and implemented an employee welfare benefit plan subject to ERISA. *Donovan v. Dillingham*, 688 F.2d 1367 (11th Cir. 1982). Further, Trans-American's purchase of the Time MET Plan is evidence of the existence of Trans-American's employee welfare benefit plan. *Id.*

This conclusion is strengthened by two slip opinions provided to the Court, reflecting decisions by other

courts holding that identical Time MET group health insurance plans are "employee welfare benefit plans" subject to ERISA: *Davis v. Time Insurance Co.*, No. H88-1048(R), slip op. (U.S. Dist. Ct., S.D. Miss. October 21, 1988) and *Time Insurance Co, Inc. v. Roberts, et al.*, No. A89A0616, combined with *W. M. Sheppard Lumber Co., Inc. v. Roberts*, No. A89A0617, slip op. (Ct. Apps. Georgia, May 24, 1989).

Plaintiff argues that the Time MET Plan cannot be treated as an employee welfare benefit plan under ERISA because Trans-American did not observe the formalities of ERISA, such as filing reports and disclosure statements, notifying employees of their rights under ERISA or identifying who the "trustee" is. Contrary to Plaintiff's argument, however, under the United States Department of Labor's current regulations pertaining to ERISA, the administrator of any employee welfare benefit plan which covers fewer than one hundred participants, such as Trans-American's, is exempt from most of ERISA's reporting and disclosure requirements. 29 Cfr. § 2520.104-20, 2520.104-21, 2520.104-41, 2520.104-43, and 2520.104-46 (1988).

Moreover, the question whether a particular employee welfare benefit plan falls within ERISA does not turn on whether an employer has complied with the formalistic technical requirements of ERISA. *Gilbert v. Burlington Industries, Inc.*, 765 F.2d 320 (2d Cir. 1985), affirmed 477 U.S. 901, 106 S. Ct. 3267, 91 L.Ed.2d 558 (1986). Thus the Time MET Plan at issue here was an employee welfare benefit plan subject to ERISA regardless of whether Trans-American followed ERISA's reporting and disclosure requirements *Id.*; *See also Donovan*, 688

F.2d at 1372 ("ERISA does not . . . require a formal, written plan.").

An ERISA employee welfare benefit plan can exist even if the employer is not significantly involved in administering the plan, even if an administrator or fiduciary under the plan has failed to satisfy reporting or plan fiduciary requirements, and even if a fiduciary is not specifically named in the insurance policy which comprises the employee welfare benefit plan. *Donovan*, 688 F.2d at 1372; *Benvenuto v. Connecticut General Life Ins. Co.*, 643 F. Supp. 87, 90-91 (D.N.J. 1986). Thus, whether or not Trans-American identified a plan fiduciary or complied with ERISA concerning the plan is irrelevant to the conclusion that the Time MET Plan at issue is an employee welfare benefit plan subject to ERISA.

Having concluded that the Time MET Plan at issue was an "employee welfare benefit plan" subject to ERISA, the next question is whether ERISA preempts the state common law claims Plaintiff has alleged against Time. Based on the Supreme Court's decisions in *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 107 S. Ct. 1549, 95 L.Ed.2d 39 (1987) and *Shaw v. Delta Airlines, Inc.*, 463 U.S. 85, 103 S. Ct. 2890, 77 L.Ed.2d 490 (1983), and the plain language of ERISA itself, it is clear that Congress intended ERISA's civil enforcement remedies to be exclusive. Indeed, the only claims *not* preempted by ERISA are those which do not "relate to any employee benefit plan under ERISA." 29 U.S.C. § 1144(a).

Because Plaintiff Karen Lunn is seeking to recover benefits allegedly due under Trans-American's employee welfare benefit plan, her claims "relate to" that plan and

are preempted by ERISA. Mrs. Lunn's remedies, if any, are available exclusively through ERISA, and she cannot maintain the common law state causes of action she has alleged in her Complaint. *Pilot Life, supra; Straub v. Western Union Telegraph Co.*, 851 F.2d 1262 (10th Cir. 1988); *cf. Sappington v. Covington*, 28 N.M. St. Bar Bull. 86 (Ct. Apps.), filed November 23, 1958 ("Where a viable employee benefit plan is created, ERISA's civil enforcement provisions provides the exclusive avenue available to Plaintiff for recovery of benefits due to him under his employer's medical benefit plan.").

Plaintiff's final argument is that ERISA cannot preempt her state law claims because she was not an employee of Trans-American's. The defect in this argument is that ERISA does not selectively preempt state law claims depending on who the Plaintiff is. If ERISA preempts the state law claims of "employees" relating to an employment welfare benefit plan, it also preempts the same state law claims for an independent contractor seeking the same benefits under the same plan.

The question whether a plaintiff's state law claims are preempted by ERISA turns on whether there exists an employee welfare benefit plan governed by ERISA, not on whether the person making a claim for benefits under such a plan was entitled to coverage under that plan. *Pane v. RCA Corp.*, 667 F. Supp. 168, 172 (D.N.J. 1987). Therefore, whether Plaintiff Karen Lunn was an independent contractor or an employee is not relevant to the issue of whether the state law claim she has alleged against Time are preempted by ERISA.

Moreover, as a matter of policy, it would undermine the broad purposes of ERISA to allow one person (an independent contractor) to assert state law claims seeking benefits allegedly due under an employee welfare benefit plan when federal law clearly preempts identical claims relating the same plan brought by other individuals (employees) who are properiy enrolled under that plan. Accordingly, the Court concludes that Plaintiff Karen Lunn's claims against Defendant Time have been pre-empted by ERISA.

On the basis of the foregoing, the Court concludes that there is no genuine issue of material fact and that Defendant Time is entitled to Summary Judgment as a matter of law.

IT IS THEREFORE ORDERED that Time's Motion for Summary Judgment be and hereby is granted and that judgment shall be and hereby is entered in Defendant's favor.

ART ENCINIAS
DISTRICT COURT JUDGE

SUBMITTED BY:

/s/ David C. Davenport
David C. Davenport, Jr.
Attorney for Defendant

APPROVED AS TO FORM:

Sam A. Westergren
Attorneys for Plaintiff

IN THE SUPREME COURT OF THE STATE OF NEW MEXICO

JERRY B. LUNN and KAREN L. LUNN,

Plaintiffs-Appellants,

vs. No. 18,872

TIME INSURANCE COMPANY,

Defendant-Appellee.

APPEAL FROM THE DISTRICT COURT OF SANTA FE COUNTY

Art Encinias, District Judge

(FILED MAY 15 1990)

Sam A. Westergren
Santa Fe, New Mexico for Appellants

Rodney, Dickason, Sloan, Akin & Robb, P.A.
David C. Davenport, Jr.
Santa Fe, New Mexico for Appellee

OPINION

BACA, Justice.

Appellants Jerry and Karen Lunn (Lunns) were cable splicers retained as independent contractors by Trans-American Communications, Inc. (Trans-American). They applied for and obtained group health insurance from Time Insurance Company (Time) through a group health insurance plan maintained as an employee welfare benefit plan by Trans-American. Mr. Lunn subsequently developed colon cancer and submitted a claim for medical expenses to Time (he has since died).

In the insurance application Mrs. Lunn represented that she was a cable splicer, but did not indicate that she

was engaged as an independent contractor. She also stated that neither she nor her husband had previously had any indication, diagnosis or treatment for cancer. In fact, Mr. Lunn had suffered previously from cancer.

While processing the medical claims submitted by Mr. Lunn, the insurer determined that Mrs. Lunn was not a full-time employee of Trans-American and therefore was not eligible for insurance coverage under the plan. Time denied the claim and attempted to return the premiums paid and to rescind coverage.

The Lunns brought suit against Time, alleging breach of contract and seeking past benefits on the insurance policy and a declaratory judgment reinstating future coverage. In a second count, they sought damages on a claim alleging bad faith and misrepresentation in Time's administration of the insurance contract and its denial of coverage.

Time moved for summary judgment, contending that the Lunns' claims based on state law were preempted by the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. Section 1144 (1988), In the Lunns' response to Time's motion, they intimated, for the first time, that they additionally were alleging negligence although they did not attempt to amend their complaint at this time. At no time did the Lunns allege a claim under ERISA.

The district court entered an order granting the summary judgment motion. In a motion to reconsider the judgment, Mrs. Lunn claimed that they had stated a cause of action in negligence, although the complaint indicates otherwise. At a hearing on the motion, appellants

attempted to orally modify the complaint. The court, at that late date, declined to rule on the motion to amend and entered the summary judgment.

Mrs. Lunn contends that the claims are not preempted by ERISA, that they stated a cause of action in negligence that is not preempted, and that the court erred in finding that the complaint did not allege negligence. We hold that the court properly found the Lunns did not allege negligence and properly granted summary judgment based on federal preemption on the two claims before it, and we affirm.

ERISA, 29 U.S.C. Section 1144(a), provides that federal law "shall supersede any and all state laws insofar as they may now or hereafter *relate to any employee benefit plan* described in Section 1003(a) of this title and not exempt under Section 1003(b) of this title." (Emphasis added.)[1] The United States Supreme Court has interpreted the scope of federal preemption and stated: "A law 'relates to' an employee benefit plan, in the normal sense of the phrase, if it has a connection with or reference to such a plan." *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 96-97 (1983). Congress intended that the preemption clause should be interpreted broadly in light of the comprehensive nature of ERISA. *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 44 (1987). Of course, the scope of preemption, although broad, is not infinite, and certain claims based on state law that in some sense relate to an ERISA plan are not preempted. *See, e.g., Fort Halifax Packing Co. v.*

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[1] It is uncontested that the plan at issue here is governed by ERISA.

Coyne, 482 U.S. 1 (1987) (no preemption where state law does not raise issues regarding concerns of ERISA – to insure administration of a plan governed by a single set of regulations and to guarantee administrative integrity); *Scott v. Gulf Oil Corp.*, 754 F.2d 1499 (9th Cir. 1985) (claim for loss of benefits that would have accumulated but for improper negotiation of terms of employment not preempted); *McNamee v. Bethlehem Steel Corp.*, 692 F. Supp. 1477 (E.D.N.Y. 1988) (breach of contract and fraud claims where employee sought damages, not benefits under plan, for alleged wrongful failure to bridge gap in employment with benefits and misrepresentation of coverage and intent to continue employment not preempted); *Local Union 212 Int'l Bhd. of Elec. Workers Vacation Trust Fund v. Local Union 212 Int'l Bhd. of Elec. Workers Credit Union*, 549 F. Supp. 1299 (S.D. Ohio 1982) (preemption requires some express or implied coverage by provision of ERISA), *aff'd* 735 F.2d 1010 (6th Cir. 1984); *Sappington v. Covington*, 108 N.M. 155, 768 P.2d 354 (Ct. App.) (compensatory damages for negligence of insurance agent in securing insurance not preempted), *cert. denied*, 108 N.M. 115, 767 P.2d 354, *cert. denied*, 109 S. Ct. 3159 (1989).

Mrs. Lunn argues that, because they were independent contractors and not employees, they were not and could not be participants in the plan, and therefore the claims do not "relate to" the plan and are not preempted. To hold otherwise, she contends, would run counter to congressional intent (to protect plan participants) and leave her with no avenue for relief. In the context of the two claims stated in the complaint, no such jurisdictional paradox is created. Supreme Court interpretation of the

federal preemption section establishes that the congressional intent was to create a comprehensive statute that broadly superseded state law and regulated pension plans "as exclusively a federal concern." *Pilot Life*, 481 U.S. at 46. It is plausible, as appellant argues, that she and her husband were not participants in the plan as defined by 29 U.S.C. Section 1002(7). *See, e.g., Darden v. Nationwide Mut. Ins. Co.*, 796 F.2d 701 (4th Cir. 1986) (defining employee for purposes of participation as one who reasonably anticipated benefits and relied thereon); *Jackson v. Sears, Roebuck & Co.*, 648 F.2d 225 (5th Cir. 1981) (plan did not cover timecard employees who were not and could not become eligible to be participants, and ERISA claim properly dismissed). If they were not, they would have no ERISA claim. Accordingly, Mrs. Lunn claims that, because neither she nor her husband were participants, their claims do not relate to the plan and are not preempted.

The errors in this theory are twofold. First, it is not clear that, at least under the definition of participant employed in *Darden*, appellants were not participants. Second, and more significant, are the claims pursued by the Lunns.

The Lunns alleged two causes of action against Time: breach of the insurance contract, and misrepresentation and bad faith in administration of the plan. Both claims relate directly to the plan. The breach of contract claim sought benefits under the plan, and the bad faith and misrepresentation claim related directly to its administration; both claims are preempted by federal law. ERISA was enacted "to protect contractually defined benefits." *Massachusetts Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 148

(1985). It is irrelevant on these claims that the Lunns may not have been participants in the plan – the suit was for benefits under the plan and damages for alleged bad faith in its administration. *See Pilot Life*, 481 U.S. at 47-48; *Straub v. Western Union Tel. Co.*, 851 F.2d 1262 (10th Cir. 1988) (breach of contract and misrepresentation claims preempted); *see also Sappington*, 108 N.M. at 159, 768 P.2d at 358 ("where plaintiff seeks to enforce a right relating to an employee benefit plan, Section 1144(a) constitutes a bar to the action because of the availability of a remedy under Section 1132(a)"). These are both claims properly brought under the enforcement provisions of ERISA, 29 U.S.C. Section 1132, yet appellant never submitted an ERISA claim. Any paradox whereby the Lunns are precluded from any forum where relief may be available is a creation of their own theories; they claim they were not and could not have been participants, yet allege causes of action based on the contract. Both counts are premised in the existence of a relationship, which, by their own theory could not exist. Accordingly, these claims are preempted.

The Lunns argue that the district court erred because they stated a claim in negligence, and that claim should not have been preempted. The court, however, properly found that the complaint did not state a claim in negligence, and it did not abuse its discretion by refusing to allow an oral motion to amend, two years after the initial complaint was filed and subsequent to its grant of the summary judgment motion.

Our reading of the complaint on its face indicates that no claim of negligence is raised, and it is apparent that the issue was not raised in the district court until late

in the proceedings. Despite Mrs. Lunn's contention, the court did not find negligence suggested by the initial pleadings. Furthermore, allegations intimated in a response to a motion for summary judgment do not constitute an amendment to a complaint, and such a response does not constitute trial "by express or implied consent of the parties" to warrant treating the allegations "as if they had been raised in the pleadings." SCRA 1986, 1-015(B).

This issue is governed by SCRA 1986, 1-015(A), which allows amendment to pleadings within the discretion of the trial court. *See Constructors, Ltd. v. Garcia*, 86 N.M. 117, 520 P.2d 273 (1974). The trial court will not be reversed absent an abuse of discretion. *Id.* Although it is true that the rule grants wide latitude to the parties by allowing leave to amend to "be freely given when justice so requires," SCRA 1986, 1-015(A), we hold that in this case, within the context of the facts before the court and the significant period of time that had elapsed prior to the oral motion to amend, there was no abuse of discretion. *See Slide-a-Ride v. Citizens Bank of Las Cruces*, 105 N.M. 433, 733 P.2d 1316 (1987).

Our resolution of this issue does not require us to determined the validity of appellants' claim that a cause of action alleging negligent underwriting would not be preempted by ERISA, and we express no opinion regarding the breadth of federal preemption of a cause of action not related directly to the plan.

We, therefore, **AFFIRM** the judgment of the district court.

IT IS SO ORDERED.

/s/ Joseph F. Baca
JOSEPH F. BACA, Justice

WE CONCUR:

/s/ Richard E. Ransom
RICHARD E. RANSOM, Justice

/s/ Seth D. Montgomery
SETH D. MONTGOMERY, Justice

IN THE SUPREME COURT OF THE STATE OF NEW MEXICO

Thursday, June 14, 1990

NO. 18,872

JERRY B. LUNN, et ux.,

Plaintiffs-Appellants,

vs.

TIME INSURANCE COMPANY,

Defendant-Appellee.

This matter coming on for consideration by the Court upon Motion of Appellant for rehearing, and the Court having considered said motion and being sufficiently advised;

NOW, THEREFORE, IT IS ORDERED that the Motion of Appellant for rehearing is hereby denied.

ATTEST: A TRUE COPY

/s/ Rose Marie Alderete
Clerk of the Supreme Court
of the State of New Mexico

IN THE SUPREME COURT OF THE STATE OF NEW MEXICO

MANDATE NO. 18,872

THE STATE OF NEW MEXICO TO THE DISTRICT COURT sitting within and for the County of Santa Fe, GREETING:

WHEREAS, in a certain cause lately pending before you, numbered SF 87-1640(C) on your Civil Docket, wherein Jerry B. Lunn, et ux where Plaintiffs and Time Insurance Company was Defendant, by your consideration in that behalf judgment was entered against said Plaintiffs; and

WHEREAS, said cause and judgment were afterwards brought into our Supreme Court for review by said Plaintiffs by appeal whereupon such proceedings were had that on May 15, 1990, an Opinion was handed down by said Supreme Court and Judgment was entered affirming your judgment aforesaid, and remanding said cause to you.

NOW, THEREFORE, this cause is hereby remanded to you for such further proceecdings [sic] therein as may be proper, if any, consistent and in conformity with said opinion and said judgment.

WITNESS, The Hon. Dan Sosa, Jr., Chief Justice of the Supreme Court of the State of New Mexico, and the seal of said Court this 14th day of June, 1990.

(SEAL)

/s/ Rose Marie Alderete
Clerk of the Supreme Court
of the State of New Mexico

IN THE FIRST JUDICIAL DISTRICT COURT
STATE OF NEW MEXICO
COUNTY OF SANTA FE

NO. SF 87-1640 (C)

(ENDORSED JUN 26 1990)

JERRY D. LUNN and KAREN L. LUNN,

Plaintiffs,

vs.

TIME INSURANCE COMPANY,

Defendant.

JUDGMENT ON THE MANDATE

THIS MATTER came before the court upon the mandate of the Supreme Court of the State of New Mexico following that court's affirmance of the trial grant of judgment in favor of the Defendant and against the Plaintiffs.

IT IS THEREFORE ORDERED that the trial court's judgment be and hereby is affirmed, in conformity with the opinion of the Supreme Court of the State of New Mexico.

/s/ Art Encinias
ART ENCINIAS, District Judge

xc: Sam A. Westergren
David Davenport

FIRST JUDICIAL DISTRICT COURT
COUNTY OF SANTA FE
STATE OF NEW MEXICO

NO. CV SF
87-1640(c)
Division

JERRY D. LUNN and wife,
KAREN L. LUNN

Plaintiffs,

vs.

TIME INSURANCE COMPANY

Defendant.

COMPLAINT AGAINST MAJOR MEDICAL INSURER

COME NOW the Plaintiffs, JERRY D. LUNN and wife, KAREN L. LUNN, by and through their attorney of record, SAM A. WESTERGREN, and for their causes of action against TIME INSURANCE COMPANY, Defendant, would show unto this Honorable Court and Jury the following:

Count One

1. The Defendant is a corporation organized and existing under and by virtue of the law of the State of Wisconsin. Defendant is engaged in the business of selling major medical insurance and other types of insurance in the State of New Mexico, and other states, and operates and has offices and agents throughout the State of New Mexico, their principal place of business in New Mexico being in the County of Santa Fe.

2. On or about February 26, 1986, Defendant issued to Plaintiffs a comprehensive major medical insurance policy. Said policy was in full force and effect at the time the Plaintiff JERRY D. LUNN developed the condition which was covered by said policy, namely colon cancer.

3. As a direct result of his disease, the Plaintiff JERRY D. LUNN incurred medical expenses, including but not limited to hospital charges, doctors' charges, medical tests and x-rays and prescription drugs, where were reasonable and necessary for the treatment of said Plaintiff's disease.

4. Under the terms of the insurance policy in question, under which both Plaintiffs were covered, the above-mentioned medical charges were "Covered Charges" under the policy in question and Defendant was contractually obligated to pay the various charges relating to and which should relate to the treatment and care of the Plaintiff JERRY D. LUNN, which, at the time of the filing of this Complaint are in excess of $60,000.

5. Plaintiffs paid all premiums due under the policy, submitted all proofs of loss required under the policy, and performed all other conditions the policy required them to perform.

6. Defendant breached the policy by failing to pay Plaintiff JERRY D. LUNN'S claim.

7. Because of its breach of the insurance contract in question, Defendant is additionaly [sic] liable for statutory penalties and reasonable attorney's fees.

WHEREFORE, PREMISES CONSIDERED, Plaintiffs pray for judgment against the Defendant for the full amount of all past covered medical charges for the treatment of the Plaintiff JERRY D. LUNN and for a declaratory judgment reinstating the contractual coverage for future medical charges for the reasonable and necessary treatment of said Plaintiff; further, Plaintiffs pray that the

applicable statutory peanalty [sic] be awarded against the Defendant, that Plaintiffs be awarded reasonable attorney's fees, and, further, Plaintiffs pray for such other and further relief to which they may be entitled.

Count Two

8. Plaintiffs incorporate in this paragraph the allegations set forth in paragraphs 1 through 7 as if they were set forth in this paragraph.

9. In denying the claims of the Plaintiff JERRY D. LUNN, the Defendant acted unreasonably and in bad faith by telling said Plaintiff, after a considerable amount of time had elapsed, that he was not covered under said policy when in fact he was covered. Defendant made false statements to both Plaintiffs to attempt to induce them to believe that there was no coverage of the extensive medical expenses.

10. That the Defendant, under the facts and circumstances of this case, owed the Plaintiffs a legal duty of good faith and fair dealing. That by fraudulently attempting to induce the Plaintiffs to believe that there was not coverage for the Plaintiff JERRY D. LUNN's extensive medical expenses, when in fact these were "Covered Charges" under the policy in question, these actions constituted a breach of a legal duty owed to Plaintiffs by Defendant.

11. The Defendant had no reasonable basis for denying coverage for the Plaintiff JERRY D. LUNN's medical expenses in this case.

12. As above alleged, Plaintiffs have incurred contractual damages in excess of $60,000, which Plaintiffs are

entitled to recover against Defendant because of said Defendant's breach of its legal duty of good faith and fair dealing owed to the Plaintiffs. In addition to their contractual damages, Plaintiffs have incurred additional damages in excess of $50,000, which damages proximately resulted from the Defendant's breach of contract as alleged in Count One. Because of the unreasonable denial of coverage, the Plaintiff JERRY D. LUNN did not receive proper medical and nursing care. As a proximate result of her spouse's lack of medical and nursing care, which are "Covered Charges" under the policy in question, the Plaintiff KAREN L. LUNN incurred an extensive loss of income and other expenses in an amount in excess of $50,000. The Plaintiffs' actual damages are in excess of $100,000.

13. As additional damages proximately resulting from Defendant's breach of its legal duty of good faith and fair dealing owed to the Plaintiffs, the Plaintiffs have suffered, and will continue to suffer for the rest of their lives, extreme mental anguish. The Plaintiff JERRY D. LUNN has a terminal illness. Although the necessary medical and hospital charges for treatment of his illness are "Covered Charges" under the policy in question, the Defendant, acting unreasonably and in bad faith, denied coverage. To have a terminal illness and not be able to afford the necessary care and treatment is mental anguish of the most severe kind, both for the Plaintiff JERRY D. LUNN who has to suffer the great pain and anguish of his last days without the proper medical care and for the Plaintiff KARREN [sic] L. LUNN who has to stand by and helplessly watch her spouse suffer. The amount of pain

and suffering and mental anguish suffered by both Plaintiffs, proximately resulting from the Defendant's breach of its covevant [sic] of good faith and fair dealing towards the Plaintiffs is in an amount in excess of $300,000.

14. That Plaintiffs would further show that the manner and method which the Defendant utilized in denying the Plaintiffs' claims under the policy in question evidence such intentional and/or wanton and reckless disregard for Plaintiffs' rights under the insurance policy in question that the Plaintiffs should be entitled to recover punitive damages from the Defendant in an amount in excess of ONE MILLION DOLLARS ($1,000,000).

WHEREFORE, PREMISES CONSIDERED, Plaintiffs pray for judgment against Defendant for its actual damages, including mental anguish; further, Plaintiffs pray for punitive damages against said Defendant in an amount in excess of ONE MILLION DOLLARS ($1,000,000); further, Plaintiffs pray for reasonable attorney's fees and for such other and further relief to which the Court may deem just and proper.

Respectfully submitted,

/s/ Sam A. Westergren
SAM A. WESTERGREN
P. O. Box 308
Ruidoso, New Mexico 88345
(505) 257-5566
Attorney for PLAINTIFFS

FIRST JUDICIAL DISTRICT COURT
COUNTY OF SANTA FE
STATE OF NEW MEXICO
NO. CV SF-87-1640(C)

JERRY D. LUNN and wife,
KAREN L. LUNN,

Plaintiffs,

vs.

TIME INSURANCE COMPANY,

Defendant.

ANSWER

COMES NOW Defendant, Time Insurance Company, by and through its attorneys of record Rodey, Dickason, Sloan, Akin & Robb, P.A. and for its answer to the complaint on file herein states as follows:

1. Defendant admits the allegations contained in Paragraph 1, except that it denies that it has any offices in New Mexico and that its principal place of business in New Mexico is in Santa Fe County.

2. Defendant denies the allegations in Paragraph 2, but states affirmatively that it issued a group health policy to Trans-American Communications, Inc., with coverage to Plaintiffs to have been effective March 1, 1986.

3. On information and belief, Defendant admits that Plaintiff Jerry D. Lunn incurred various medical expenses, but Defendant is without sufficient information to form a belief as to the truth of the matters asserted in the remaining allegations of Paragraph 3 and therefore denies the same.

4. Defendant denies the allegations contained in Paragraphs 4, 5, 6, 7, 9, 10, 11 and 14.

5. In response to Paragraph 8 of the complaint, Defendant incorporates its responses to the allegations set forth in Paragraphs 1 through 4 above as if they were set forth herein.

6. In response to the allegations contained in Paragraph 12 of the complaint, Defendant admits that Plaintiff Jerry D. Lunn incurred various medical expenses, but is without information sufficient to form a belief as to the amount of those expenses, and further, that Defendant is without information sufficient to form a belief as to the truth of the allegation that "the Plaintiff JERRY D. LUNN did not receive proper medical and nursing care," and therefore denies the same. Defendant denies all remaining allegations in Paragraph 12 of the complaint.

7. In response to the allegations contained in Paragraph 13 of the complaint, Defendant states on information and belief that Plaintiff Jerry D. Lunn is deceased. Defendant is without information sufficient to form a belief as to the truth of the allegations contained in the fourth sentence in Paragraph 13 of the complaint and therefore denies the same. Defendant denies all remaining allegations in Paragraph 13 of the complaint.

FIRST AFFIRMATIVE DEFENSE

Plaintiffs did not qualify for benefits under the group health policy Defendant had issued to Trans-American Communications, Inc., because a claimant under that policy must have been a full-time employee of Trans-American Communications, Inc. or a spouse of such an

employee, and Plaintiff Karen L. Lunn was not such an employee, but was in fact an independent contractor.

SECOND AFFIRMATIVE DEFENSE

Any certificate of insurance issued by Defendant to Plaintiffs or any insurance coverage extended by Defendant to Plaintiffs was void or voidable at the election of Defendant by reason of misrepresentation of material facts by Plaintiff Karen L. Lunn, or by reason of mutual mistake of fact, or by reason of mistake of fact on Defendant's part and inequitable conduct on the part of Plaintiff Karen L. Lunn in one or more of the following respects:

(a) In her application for enrollment dated February 27, 1986, Plaintiff Karen L. Lunn stated that neither she nor her husband Jerry D. Lunn "ever had any indication, diagnosis or treatment for . . . cancer or malignancy," which statement was not true;

(b) In her application for enrollment dated February 27, 1986, Plaintiff Karen L. Lunn stated that neither she nor her husband Jerry D. Lunn "ever had any indication, diagnosis or treatment for . . . heart disorder or stroke," which statement was not true; and

(c) In her application for enrollment dated February 27, 1986, Plaintiff Karen L. Lunn stated that she was an employee of Trans-American Communications, Inc., which statement was not true.

THIRD AFFIRMATIVE DEFENSE

Any insurance certificate issued by Defendant to Plaintiffs or any insurance coverage extended by Defendant to Plaintiffs was subject to rescission and was

rescinded by Defendant by reason of misrepresentation of material facts by Plaintiff Karen L. Lunn, or by reason of mutual mistake of fact, or by reason of mistake of fact on Defendant's part and inequitable conduct on the part of Plaintiff Karen L. Lunn in one or more of the following respects:

(a) In her application for enrollment dated February 27, 1986, Plaintiff Karen L. Lunn stated that neither she nor her husband Jerry D. Lunn "ever had any indication, diagnosis or treatment for . . . cancer or malignancy," which statement was not true;

(b) In her application for enrollment dated February 27, 1986, Plaintiff Karen L. Lunn stated that neither she nor her husband Jerry D. Lunn "ever had any indication, diagnosis or treatment for . . . heart disorder or stroke," which statement was not true; and

(c) In her application for enrollment dated February 27, 1986, Plaintiff Karen L. Lunn stated that she was an employee of Trans-American Communications, Inc., which statement was not true.

FOURTH AFFIRMATIVE DEFENSE

Plaintiffs' claims are barred by one or more of the following misrepresentations of material fact contained in Plaintiff Karen L. Lunn's application for enrollment, which misrepresentations were reasonably relied upon by Defendant:

(a) That prior to February 27, 1986, neither she nor her husband Jerry D. Lunn "ever had any indication, diagnosis, or treatment for . . . cancer or malignancy;"

(b) That prior to February 27, 1986, neither she nor her husband Jerry D. Lunn "ever had any indication, diagnosis, or treatment for . . . heart disorder or stroke;" and

(c) That at the time of her application for insurance on February 27, 1986, she was an employee of Trans-American Communications, Inc.

FIFTH AFFIRMATIVE DEFENSE

Plaintiffs' claims are barred because the risk was not insurable and to attempt to insure such risk would be against public policy.

SIXTH AFFIRMATIVE DEFENSE

Plaintiffs' claims are barred by Plaintiff Karen L. Lunn's inequitable conduct or unclean hands or failure to act in good faith toward Defendant.

SEVENTH AFFIRMATIVE DEFENSE

If it should appear that Defendant's tender of premiums was accepted, then either a novation or rescission occurred and the Plaintiffs have no claim.

EIGHTH AFFIRMATIVE DEFENSE

Any of Plaintiffs' claims other than for benefits due under the insurance policy at issue are preempted by federal law and such claims are barred under the Constitution of the United States by reason of the Supremacy Clause.

NINTH AFFIRMATIVE DEFENSE

Plaintiffs' claims are groundless, and under applicable law Defendant is entitled to recover its attorney's fees and costs in this action.

TENTH AFFIRMATIVE DEFENSE

Defendant has been informed that Plaintiff Jerry D. Lunn is deceased.

WHEREFORE Defendant prays that the Court dismiss the claims of Plaintiffs herein, award Plaintiffs nothing on their complaint, and award Defendant its attorney's fees and costs.

Respectfully submitted,

RODEY, DICKASON, SLOAN,
AKIN & ROBB, P.A.

By/s/ David C. Davenport
Jonathan Hewes
David C. Davenport, Jr.
Attorneys for Defendant Time
Insurance Company
Post Office Box 1357
Santa Fe, New Mexico 87504-1357
Telephone: (505) 984-0100

We hereby certify that a copy of the foregoing pleading was mailed to opposing counsel of record this 28th day of September, 1987.

RODEY, DICKASON, SLOAN, AKIN & ROBB, P.A.

By/s/ David C. Davenport, Jr
David C. Davenport, Jr.

EXHIBIT D

TIME INSURANCE COMPANY

515 West Wells • Milwaukee, WI 53203

EMPLOYEE
ENROLLMENT FORM

Form 15730 (Rev. 2-85)

TIME

CASE: _____ UNIT: _____ EMP: 5

EMPLOYEE INFORMATION
(Print All Information, Do Not Punctuate)

Case # (if existing): _____

Business Name: Trans American Communications

Employee Name:
First: Karen Init: L Last: Lunn
Suffix (if any): _____

Employee Address: 10637 Edgemere Blvd
Apt C3
City: El Paso State: TX
Zip Code: 79925

Employee Sex (M=Male; F=Female): F

Birthdate: 09-04-47 Soc. Sec.#: 462-47-6218

Marital Status (S=Single; M=Married; D=Divorced; T=Separated): M

Employee's Height: 5'3" Weight: 130

Spouse's Height: 5'10" Weight: 160

Date Employed Full-Time (Month, Date, Year): 01-02-86

Requested Effective Date: 03-01/86

Annual Salary $27,744.00

Job Duties: Cable Splicer

COVERAGE REQUESTED

Life/AD&D Amount: $15,000
Disability Amount: -0-/week

Medical: Single: ____ Family: E & S
Dental: Single ____ Family ____

Beneficiary:
First Name: Jerry Initial: B. Last Name: Lunn
Relationship: Husband

EVIDENCE OF INSURABILITY

IMPORTANT!!!

Provide complete details to Questions 1 through 3 which have been answered YES. Include dates of, reasons for & results of treatment. Include dependent's names and ages if applicable. (Use back of this form if more room is needed.)

To the best of your knowledge and belief, have you or any family member applying for insurance:

1. Ever had any indication, diagnosis or treatment for:

	YES	NO
a. cancer or malignancy?	[ ]	[✔]
b. diabetes or gout?	[ ]	[✔]
c. asthma, emphysema or respiratory disorder?	[✔]	[ ]
d. heart disorder or stroke?	[ ]	[✔]
e. arthritis or a back problem?	[ ]	[✔]
f. ulcer or digestive disorder?	[ ]	[✔]
g. genito-urinary disorder?	[ ]	[✔]
h. mental or nervous disorder?	[ ]	[✔]
i. use of alcohol or drugs?	[ ]	[✔]
2. Been confined to a hospital or similar institution within the past 5 years?	[ ]	[✔]

3. Been seen or treated by a physician or taken any medication within the past two years? [✔] [ ]

I hereby authorize my employer to deduct from my earnings the proper deductions, if any, as contributions towards the cost of this insurance. I am employed by the employer listed and regularly work at least 30 hours per week. I request insurance coverage under the group policy(ies) issued by Time Insurance.

I represent that all statements and answers to the above questions are complete and true to the best of my knowledge and belief. I apply for insurance to be issued solely in reliance upon this application. I understand that the insurance contains a two year contestability period in the event of material misrepresentation.

Applicant's Signature: Karen L. Lunn
Dated at: El Paso, Tx. Date: Feb. 27, 86

SUBTITLE A-General Provisions

29 U.S.C. Sec. 1001. Congressional findings and declaration of Policy

(a) Benefit plans as affecting interstate commerce and the Federal taxing power

The Congress finds that the growth in size, scope, and numbers of employee benefit plans in recent years has been rapid and substantial; that the operational scope and economic impact of such plans is increasingly interstate; that the continued well-being and security of millions of employees and their dependents are directly affected by these plans; that they are affected with a national public interest; that they have become an important factor affecting the stability of employment and the successful development of industrial relations; that they have become an important factor in commerce because of the interstate character of their activities, and of the activities of their participants, and the employers, employee organizations, and other entities by which they are established or maintained; that a large volume of the activities of such plans is carried on by means of the mails and instrumentalities of interstate commerce; that owing to the lack of employee information and adequate safeguards concerning their operation, it is desirable in the interests of employees and their beneficiaries, and to provide for the general welfare and the free flow of commerce, that disclosure be made and safeguards be provided with respect to the establishment, operation, and administration of such plans; that they substantially affect the revenues of the United States because they are afforded preferential Federal tax treatment; that despite the enormous growth in such plans many employees with

long years of employment are losing anticipated retirement benefits owing to the lack of vesting provisions in such plans; that owing to the inadequacy of current minimum standards, the soundness and stability of plans with respect to adequate funds to pay promised benefits may be endangered; that owing to the termination of plans before requisite funds have been accumulated, employees and their beneficiaries have been deprived of anticipated benefits; and that it is therefore desirable in the interests of employees and their beneficiaries, for the protection of the revenue of the United States, and to provide for the free flow of commerce, that minimum standards be provided assuring the equitable character of such plans and their financial soundness.

(b) Protection of interstate commerce and beneficiaries by requiring disclosure and reporting, setting standard of conduct, etc., for fiduciaries

It is hereby declared to be the policy of this chapter to protect interstate commerce and the interests of participants in employee benefit plans and their beneficiaries, by requiring the disclosure and reporting to participants and beneficiaries of financial and other information with respect thereto, by establishing standards of conduct, responsibility, and obligation for fiduciaries of employee benefit plans, and by providing for appropriate remedies, sanctions, and ready access to the Federal courts.

(c) Protection of interstate commerce, the Federal taxing power, and beneficiaries by vesting of accrued benefits, setting minimum standards of funding, requiring termination insurance

It is hereby further declared to be the policy of this chapter to protect interstate commerce, the Federal taxing

power, and the interests of participants in private pension plans and their beneficiaries by improving the equitable character and the soundness of such plans by requiring them to vest the accrued benefits of employees with significant periods of service, to meet minimum standards of funding, and by requiring plan termination insurance.

29 U.S.C. Sec. 1001a. Additional Congressional findings and declaration of policy

(a) Effects of multi-employer pension plans

The Congress finds that –

(1) multiemployer pension plans have a substantial impact on interstate commerce and are affected with a national public interest;

(2) multiemployer pension plans have accounted for a substantial portion of the increase in private pension plan coverage over the past three decades;

(3) the continued well-being and security of millions of employees, retirees, and their dependents are directly affected by multiemployer pension plans; and

(4) (A) withdrawals of contributing employers from a multi-employer pension plan frequently result in substantially increased funding obligations for employers who continue to contribute to the plan, adversely affecting the plan, its participants and beneficiaries, and labor-management relations; and

(B) in a declining industry, the incidence of employer withdrawals is higher and the adverse effects described in subparagraph (A) are exacerbated.

(b) Modification of multiemployer plan termination insurance provisions and replacement of program

The Congress finds that –

(1) it is desirable to modify the current multiemployer plan termination insurance provisions in order to increase the likelihood of protecting plan participants against benefit losses; and

(2) it is desirable to replace the termination insurance program for multiemployer pension plans with an insolvency-based benefit protection program that will enhance the financial soundness of such plans, place primary emphasis on plan continuation, and contain program costs within reasonable limits.

(c) Policy

It is hereby declared to be the policy of this Act –

(1) to foster and facilitate interstate commerce,

(2) to alleviate certain problems which tend to discourage the maintenance and growth of multiemployer pension plans.

(3) to provide reasonable protection for the interests of participants and beneficiaries of financially distressed multiemployer pension plans, and

(4) to provide a financially self-sufficient program for the guarantee of employee benefits under multi-employer plans.

Sec 100b. Additional Congressional findings and declarations of policy; single-employer plan termination insurance

(a) Findings

The Congress finds that –

(1) single-employer defined benefit pension plans have a substantial impact on interstate

commerce and are affected with a national interest;

(2) the continued well-being and retirement income security of millions of workers, retirees, and their dependents are directly effected by such plans;

(3) the existence of a sound termination insurance system is fundamental to the retirement income security of participants and beneficiaries of such plans; and

(4) the current termination insurance in some instances encourages employers to terminate pension plans, evade their obligations to pay benefits, and shift unfunded pension liabilities onto the termination insurance system and the other premium-payers.

(b) Additional findings

The Congress further finds that modification of the current termination insurance system and an increase in the insurance premiums for single-employer defined benefit pension plans –

(1) is desirable to increase the likelihood that full benefits will be paid to participants and beneficiaries of such plans;

(2) is desirable to provide for the transfer of liabilities to the termination insurance system only in cases of severe hardship;

(3) is necessary to maintain the premium costs of such system at a reasonable level; and

(4) is necessary to finance properly current funding deficiencies and future obligations of the single-employer pension plan termination insurance system.

(c) Declaration of policy

It is hereby declared to be the policy of this title –

(1) to foster and facilitate interstate commerce;

(2) to encourage the maintenance and growth of single-employer defined benefit pension plans;

(3) to increase the likelihood that participants and beneficiaries under single-employer defined benefit pension plans will receive their full benefits;

(4) to provide for the transfer of unfunded pension liabilities onto the single-employer pension plan termination insurance system only in cases of severe hardship;

(5) to maintain the premium costs of such system at a reasonable level; and

(6) to assure the prudent financing of current funding deficiencies and future obligations of the single-employer pension plan termination insurance system by increasing termination insurance premiums.

29 U.S.C. Sec. 1002. Definitions

For purposes of this subchapter:

(1) The terms "employee welfare benefit plan" and "welfare plan" mean any plan, fund, or program which was heretofore or is hereafter established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, (A) medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident,

disability, death or unemployment, or vacation benefits, apprenticeship or other training programs, or day care centers, scholarship funds, or prepaid legal services, or (B) any benefit described in section 186(c) of this title (other than pensions on retirement or death, and insurance to provide such pensions).

(2) (A) Except as provided in subparagraph (B), the terms "employee pension benefit plan" and "pension plan" mean any plan, fund, or program which was heretofore or is hereafter established or maintained by an employer or by an employee organization, or both, to the extent that by its express terms or as a result of surrounding circumstances such plan, fund, or program –

(i) provides retirement income to employees, or

(ii) results in a deferral of income by employees for periods extending to the termination of covered employment or beyond,

regardless of the method of calculating the contributions made to the plan, the method of calculating the benefits under the plan or the method of distributing benefits from the plan.

(B) The Secretary may by regulation prescribe rules consistent with the standards and purposes of this chapter providing one or more exempt categories under which –

(i) severance pay arrangements, and

(ii) supplemental retirement income payments, under which the pension benefits of retirees or their beneficiaries are supplemented to take into account some portion or all of the increases in the cost of living (as determined by the Secretary of

Labor) since retirement, shall, for purposes of this subchapter, be treated as welfare plans rather than pension plans. In the cases of any arrangement or payment a principal effect of which is the evasion of the standards or purposes of this chapter applicable to pension plans, such arrangement or payment shall be treated as a pension plan.

(3) The term "employee benefit plan" or "plan" means an employee welfare benefit plan or an employee pension benefit plan or a plan which is both an employee welfare benefit plan and an employee pension benefit plan.

(4) The term "employee organization" means any labor union or any organization of any kind, or any agency or employee representation committee, association, group, or plan, in which employees participate and which exists for the purpose, in whole or in part, of dealing with employers concerning an employee benefit plan, or other matters incidental to employment relationships; or any employees' beneficiary association organized for the purpose in whole or in part, of establishing such a plan.

(5) The term "employer" means any person acting directly as an employer, or indirectly in the interest of an employer, in relation to an employee benefit plan, and includes a group or association of employers acting for an employer in such capacity.

(6) The term "employee" means any individual employed by an employer.

(7) The term "participant" means any employee or former employee of an employer, or any member or former member of an employee organization, who is or may become eligible to receive a benefit of any type from an employee benefit

plan which covers employees of such employer or members of such organization, or whose beneficiaries may be eligible to receive any such benefit.

(8) The term "beneficiary" means a person designated by a participant, or by the terms of an employee benefit plan, who is or may become entitled to a benefit thereunder.

(9) The term "person" means an individual, partnership, joint venture, corporation, mutual company, joint-stock company, trust, estate, unincorporated organization, association, or employee organization.

(13) The term "Secretary" means the Secretary of Labor.

(14) The "party in interest" means, as to an employee benefit plan –

(A) Any fiduciary (including, but not limited to, any administrator, officer, trustee, or custodian), counsel, or employee of such employee benefit plan;

(B) a person providing services to such plan;

(C) an employer any of whose employees are covered by such plan;

(D) an employee organization any of whose members are covered by such plan;

(E) an owner, direct or indirect, of 50 percent or more of –

(i) the combined voting power of all classes of stock entitled to vote or the total value of shares of all classes of stock of a corporation.

(ii) the capital interest or the profits interests of a partnership, or

(iii) the beneficial interest of a trust or unincorporated enterprise,

which is an employer or an employee organization described in subparagraph (C) or (D);

(F) a relative (as defined in paragraph (15) of any individual described in subparagraph (A), (B), (C), or (E);

(G) a corporation, partnership, or trust or estate of which (or in which) 50 percent or more of –

(i) the combined voting power of all classes of stock entitled to vote or the total value of shares of all classes of stock of such corporation,

(ii) the capital interest or profits interest of such partnership, or

(iii) the beneficial interest of such trust or estate,

is owned directly or indirectly, or held by persons described in subparagraph (A), (B), (C), (D), or (E);

(H) an employee, officer, director (or an individual having powers or responsibilities similar to those of officers or directors), or a 10 percent or more shareholder directly or indirectly, of a person described in subparagraph (B), (C), (D), (E), or (G), or of the employee benefit plan; or

(I) a 10 percent or more (directly or indirectly in capital or profits) partner of a person described in subparagraph (B), (C), (D), (E), or (G).

The Secretary, after consultation and coordination with the Secretary of the Treasury, may by regulation prescribe

a percentage lower than 50 percent for subparagraph (E) and (G) and lower than 10 percent for subparagraph (H) or (I). The Secretary may prescribe regulations for determining the ownership (direct or indirect) of profits and beneficial interests, and the manner in which indirect stockholdings are taken into account. Any person who is a party in interest with respect to a plan to which a trust described in section 501(c)(22) of Title 26 is permitted to make payments under section 1403 of this title shall be treated as a party in interest with respect to such trust.

(15) The term "relative" means a spouse, ancestor, lineal descendant, or spouse of a lineal descendant.

(16) (A) The term "administrator" means –

(i) the person specifically so designated by the terms of the instrument under which the plan is operated.

(ii) if an administrator is not so designated, the plan sponsor; or

(iii) in the case of a plan for which an administrator is not designated and a plan sponsor cannot be identified, such other person as the Secretary may be [sic] regulation prescribe.

(B) The term "plan sponsor" means (i) the employer in the case of an employee benefit plan established or maintained by a single employer, (ii) the employee organization in the case of a plan established or maintained by an employee organization; or (iii) in the case of a plan established or maintained by two or more employers or jointly by one or more employers and one or more employee organizations, the association, committee, joint board of trustees,

or other similar group of representatives of the parties who establish or maintain the plan.

(17) The term "separate account" means an account established or maintained by an insurance company under which income, gains, and losses, whether or not realized, from assets allocated to such account, are, in accordance with the applicable contract, credited to or charged against such account without regard to other income, gains, or losses of the insurance company.

29 U.S.C. Sec. 1132. Civil enforcement

(a) Persons empowered to bring a civil action

A civil action may be brought –

(1) by a participant or beneficiary –

(A) for the relief provided for in subsection (c) of this section, or

(B) to recover benefits due to him under the terms of his plan, to enforce the rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan;

(2) by the Secretary, or by a participant, beneficiary or fiduciary for appropriate relief under section 1109 of this title;

(3) by a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provision of this subchapter or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this subchapter or the terms of this plan;

(4) by the Secretary, or by a participant, or beneficiary for appropriate relief in the case of a violation of 1025(c) of this title;

(5) except as otherwise provided in subsection (b) of this section, by the Secretary (A) to enjoin any act or practice which violates any provision of this subchapter, or (B) to obtain other appropriate equitable relief (i) to redress such violation or (ii) to enforce any provision of this subchapter; or

(6) by the Secretary to collect any civil penalty under subsection (i) of this section.

(e) Jurisdiction

(1) Except for actions under subsection (a)(1)(B) of this section, the district courts of the United States shall have exclusive jurisdiction of civil actions under this subchapter brought by the Secretary or a participant, beneficiary or fiduciary. State courts of competent jurisdiction and district courts of the United States shall have concurrent jurisdiction of actions under subsection (a)(1)(B) of this section.

(2) Where an action under this subchapter is brought in a district court of the United States, it may be brought in the district were [sic] the plan is administered, where the breach took place, or where a defendant resides or may be found, and process may be served in any other district where a defendant resides or may be found.

(f) Amount in controversy; citizenship of parties

The district courts of the United States shall have jurisdiction, without respect to the amount in controversy or the citizenship of the parties, to grant the relief provided for in subsection (a) of this section in any action.

29 U.S.C. Sec. 1144 Other laws.

(a) Supersedure; effective date

Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title. This section shall take effect on January 1, 1975.